## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Main Rehab & Diagnosti 3710 Rawlins, Ste. 1400		( ) IC Response Timely	Dilado () Mas ( ) Ma		
Main Rehab & Diagnosti 710 Rawlins, Ste. 1400	ddress	• •	*		
3710 Rawlins, Ste. 1400	Requestor's Name and Address Main Rehab & Diagnostic 3710 Rawlins, Ste. 1400		MDR Tracking No.: M4-04-2845-01 TWCC No.:		
Dallas, TX 75219					
	Dallas, TX 75219		Injured Employee's Name:		
Respondent's Name and Address Winn Dixie Louisiana, Inc. c/o Harris & Harris		Date of Injury:			
		Employer's Name:	Employer's Name: Winn Dixie Louisiana, Inc.		
P.O. Box 162443		Insurance Carrier's	Insurance Carrier's No		
Austin, TX 78716 BOX 42		insulative currer of	A11120179900010111		
PART II: SUMMAR	RY OF DISPUTE ANI	O FINDINGS (Details on Page 2, if needed)			
Dates o	of Service	CDT C I ( ) D i i	, , , , , , , , , , , , , , , , , , ,	, (P	
From	То	CPT Code(s) or Description	Amount in Dispute	<b>Amount Due</b>	
		99213, 97265, 97110, 97032, 97750-			
07/14/03	07/31/03	MT, 95851	\$519.00	\$519.00	
+					
PART III: REQUES	STOR'S POSITION S	UMMARY			
			ately reduced the medical fo	ees which were cha	
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PART VII: COMMISSION DECISION AND ORDER					
Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$519.00. The Division hereby <b>ORDERS</b> the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.  Ordered by:					
	Marguerite Foster	02/11/05			
Authorized Signature	Typed Name	Date of Order			
PART VIII: YOUR RIGHT TO REQUEST A HEARING					
Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.  Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.					
PART IX: INSURANCE CARRIER DELIVER	RY CERTIFICATION				
I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.					
Signature of Insurance Carrier:		Date:			